DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
1216 STANLEY ROAD, SUITE 25
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO
ATTENTION OF
MCHS-IS

29 March 2004

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Minutes of the US Army Medical Command Data Quality for AMEDD Success Team (DQFAST)

1. The DQFAST met in Room 107, US Army Patient Administration Systems and Biostatistics Activity (PASBA) Conference Room, Building 126, at 0900 on 16 March 2004.

a. Members Present:

COL Larry J. Clark, Team Leader, PASBA
LTC Leo Bennett, Quality Management Division (QMD), MEDCOM
Ms. Garnet Robinson, Data Quality Section, PASBA
Mr. Gregory Padilla, Resource Management (RM), MEDCOM
Mr. Timothy Fannin, Internal Review, MEDCOM
Mr. Ronnie James, Data Analysis Section, PASBA
Ms. Joan Richwine, IBA (via teleconference)

b. Members Absent:

LTC Marta Davidson, MEDCOM
LTC Petray, RM, MEDCOM
MAJ Deborah Wesloh, Deputy Director, PASBA
MAJ Joan Ulsher, Decision Support Branch, PASBA
MAJ Deidra Briggs-Anthony, Data Management Branch, PASBA
CPT Blocker, Decision Support Cell, Office of he Surgeon General (OTSG)
Ms. Mona Bacon, Army MEPRS Program Office (AMPO), MEDCOM
Ms. Sherri Mallett, Coding and Training Section, PASBA
Ms. Jo Anne Cyr, Program, Analysis and Evaluation, MEDCOM
Mr. DeWayne Beers, Internal Review, MEDCOM
Ms. Jan Leaders, TRICARE Operation Division, MEDCOM

c. Others Present:

Mr. Harold Cardenas, representing AMPO
Ms Paulette Richards, representing LTC Petray, RM, MEDCOM
Mr. Tim Bacon, Data Quality Section, PASBA

2. Opening Remarks. COL Clark informed the members that he had no opening remarks, but did have comments which he would make during the course of the meeting.

3. Old/Ongoing Business.

a. Approval of Minutes. The February 2004 minutes were approved as written.

b. Quality Management.

(1) Clinical/Clinical Practice Guidelines (CPGs). LTC Bennett reported that COL Young sent a message to MAJ Briggs-Anthony on 24 February 2004 indicating it would be alright to discontinue the CPG link from the PASBA website and to provide a link that would direct all users to the Military Population Health Portal.

(2) LTC Bennett and COL Young were at the Veterans Administration (VA) last week and worked with the CPG working group. He didn't feel there were any new initiatives undertaken that needed to be addressed at this time.

(3) LTC Bennett noted that the new policy AR 40-68, Clinical Quality Management has been published. The new regulation, dated 26 February 2004 will become effective 26 March 2004. It is available for viewing at the USAPA website and the MEDCOM, Quality Management website http://www.qmo.amedd.army.mil. The first three chapters have undergone significant revision. They describe the Clinical Quality Management Program (CQMP) for the AMEDD. The MEDCOM QMD has reviewed the DoDD 6025.13 (DRAFT) for DoD/HA/TMA -- to be an updated document for policy for quality management in the Department of Defense.

(4) The Office of the Assistant Secretary of Defense (Health Affairs) is recommending a change to the clinical quality measures in the Military Health System (MHS) Balanced Scorecard. Proposed inpatient metrics include neonatal mortality, pneumonia antibiotic timing, surgical infection prophylaxis and beta blocker after myocardial infarction. The outpatient metrics include breast cancer screening, diabetes management (HgbA1C) and asthma management. These metrics have been presented to the MHS Standard Metric Board and the TRICARE Clinical Quality Forum. COL Dorothy Smith, OTSG, Executive Information and Decision Support has sought input from MEDCOM QMD staff and is requesting feedback. LTC Bennett stated he would forward this email to anyone on the DQFAST wishing to see it.

c. Data Quality.

(1) Metrics. Mr. Bacon discussed the Provider Specialty Code metric (Enclosure 1). February data could not be gathered due to technical problems, but the January data revealed 82 percent compliance. Questions are still arising regarding clarification and the impact of this metric. Answers are being provided by the Data Quality Section and others, based on the level of questions. North Atlantic Regional Medical Command Region appears to have the most questions. The impression is that they want to ensure clarity and purpose as to the data they will be providing. COL Clark mentioned he remembered the importance placed on this metric and how it had been stressed to the commands. The PASBA website contains the same information.

(2) DQMC Program Issues. Ms. Robinson distributed the current list of taskers received from the Deputy Surgeon General (Enclosure 2). The February report revealed normal outliers

and coding timeliness, outpatient coding accuracy and the filing and maintenance of DD Form 2569, Other Health Insurance information. For coding timeliness: 76 percent compliance for completing coding within 3 business days, 77 percent compliance for completing Ambulatory Procedure visit coding within 15 calendar days, and 86 percent compliance for completing coding within 30 days of discharge for inpatient care. For accuracy: Evaluation and Management (E&M) coding was 82 percent, International Classification of Diseases-9th Revision (ICD-9) coding was 84 percent, and Current Procedural Terminology (CPT) coding was 79 percent. In regards to timeliness and accuracy issues, taskers #10, 1, and 13 are of importance. Item 10 concerns inpatient coding which contain some notable outliers. Ft Bragg reported Ø percent, which would indicate they did not complete any inpatient coding in December and Ft Gordon had been in the single-digit compliance zone for the last several months. Based on this information, COL Clark called several individuals to discuss the issue. We will be monitoring this to see if there is any improvement in the future as a result of the conversation with Chiefs of Staff and the Patient Administration Division (PAD) officers. Item 11, page 3, concerns the Inpatient coding audits. Ft Bragg had no records to audit because they did not complete the coding and attributed the problem to a lack of staff. MG Farmer asked COL Clark to look into the possibility of negotiating some sort of workers required contract. COL Clark stated that he contacted LTC Stephens and it was agreed that a Statement of Work would be written and sent to all possible vendors for feedback. This is still an ongoing issue. Item 13, Outpatient Coding accuracy, there are a number of issues showing up in the comments regarding training, i.e., over coding, under coding, Super Bills and Cheat Sheets are wrong. A number of these issues will be addressed at the next coding video teleconference on 6 April 2004. For the collection of other health insurance, maintenance and filing of the form in the medical record, the Army's average is 46 percent, 44 percent, and 48 percent compliance. This is not a new requirement, it is a requirement that most medical treatment facilities (MTFs) have been overlooking. Refer to item 7 of the Taskers. Item 15, MG Farmer expects a quick fix. COL Clark relayed expectations to the Regional Medical Command's PADs during the telephone conference on 10 March 2004.

d. Coding.

(1) Current Issues/Solutions. Mr. James informed the members that current release of Composite Health Care System for Workload Assignment Module and Health Insurance Portability and Accountability Act, affected the Standard Inpatient Data Record by showing total bed days of the facility, but it will not show a breakdown of bed days by clinical service. A System Incident Report was submitted. The Clinical Information Technology Program Office (CITPO) informed Mr. James that the code to rectify this issue had been written and tested internally and will be sent to a site for testing. If successful, there would be an immediate worldwide release. Further, Mr. James has asked that since 5000 Army inpatient records will have to be recalculated, that CITPO develop an automated fix to eliminate the need for human intervention to correct the records. We expect an update by the end of this week.

(2) Systems Status: Coding Compliance Editor (CCE): Mr. James reported that he and MAJ Ulsher will be going to Ft Sill next week, along with representatives from Resource Information Technology Program Office and OTSG. The purpose of the visit is to kick off CCE and make some initial assessments in the basic training on the CCE.

(3) Advance-Med Audits: Nothing to report at this time.

(4) COL Clark commented that some potential resolutions are to develop coding guidelines per specialty. MAJ Ulsher and Mr. James will present the Army's coding guidelines per specialty to the Unified Biostatistical Utility (UBU) the end of April. They will also do a presentation on Anesthesia, Occupational Therapy/Physical Therapy, and Speech Pathology at the UBU. The PASBA will continue working on developing more specialty guidelines.

e. Resource Management.

(1) Current Resource Management Issues: No updates at this time.

(2) Medical Expense and Performance Reporting System (MEPRS): Mr. Harold Cardenas reported that they are currently working on the Business Rules for all the readiness accounts (MEPRS GXXX accounts). The issue is whether healthcare dollars are being recorded in readiness, which would indicate that budget dollars are being spent on readiness instead of the Global War on Terrorism dollars. His department feels that it is a matter of Budget not coding their transactions correctly. Budget has sent out guidance to all sites indicating which codes to use, but it is not reflected in the current system data.

f. Data Quality for Deployed Units. COL Clark reported we are receiving data via the PAD Tool, from the 31st Combat Support Hospital (CSH) and the 67th CSH. Both units; however, are not reporting both inpatients and outpatients in the PAD Tool. The 325th CSH will be deploying to Afghanistan by the end of March 2004. Weekly in progress reviews (IPRs) are being conducted with the TO&E PAD Chiefs to discuss workload, workload reports, and other PAD related issues. As a result of the IPRs, an issue has been raised referencing the ambulatory module in the PAD Tool that was designed to capture the minimum data elements necessary to create a Standard Ambulatory Data Record. Based on the volume of sick call patients being seen and the lack of PAD personnel, we may have to modify the ambulatory reporting requirements. COL Clark, COL Arroyo, MAJ Briggs-Anthony and others, will further discuss the process on the data we wish to capture for ambulatory care by clinical service. The sick call module of the PAD Tool appears too cumbersome and overwhelming for the field units to manage.

4. New Business. LTC Bennett reminded some of the DQFAST membership that in September, PASBA staff met with TSG's Medical Corps consultants in the setting of staff coming from the Dartmouth Center for Evaluative Clinical Sciences (CECS) who gave presentations about Small Area Variation – also known as Unwarranted Variation – as is presented in the Dartmouth Atlas. This is a conventional epidemiologic mapping method for visual portrayal of disease or care practice patterns – these methods are of particular interest to LTG Peake. Talks are continuing with Dartmouth CECS staff, the experts in these methods. While recently meeting with the VA/DoD National CPG Council, LTC Bennett learned that the VA has done the equivalent of the Dartmouth Atlas for the VA. The VA produced Veterans Affairs Healthcare Atlas through their Quality Enhancement Research Initiatives program. Contacts exist should the AMEDD desire to do this type of analysis in the future. In addition, MEDCOM QMD is working on the AMEDD Balanced Scorecard initiative IP-15, Best Practices.

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This may require some data input. The MEDCOM QMD will keep the committee informed of this work.

5. The meeting adjourned at 0945. The next meeting will be 20 April 2004.

2 Encls
as

LARRY J. CLARK
COL, MS
DQFAST Team Leader

DISTRIBUTION:
1-Each Committee Member
Deputy Surgeon General

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DEBORAH WESLOH
MAJ, MS
Deputy Director, PASBA

JOAN ULSHER
MAJ, MS
Chief, Decision Support Branch

GARNET ROBINSON
Chief, Data Quality Section

JOE ALLEY
Data Quality Section

Metrics